WESTERN WASHINGTON MEDICAL GROUP
Amaleswari Pamarthy, MD
Emily Huang, M.D.
Mark Gunning, M.D., M.R.C.P.
DEPARTMENT OF NEPHROLOGY
1330 ROCKEFELLER, SUITE 450 • EVERETT, WA 98201

Telephone No.
Office: (425) 258-6801
Fax: (425) 258-1944

HAVE YOU HAD ANY OF THE FOLLOWING DURING THE PAST ONE-YEAR?

PLEASE PRINT

PATIENT NAME: _____ DATE OF BIRTH: _____

CONSTITUTIONAL		
Recent weight change	No	Yes
Fever	No	Yes
Night sweats or chills	No	Yes
Fatigue	No	Yes
Daytime drowsiness	No	Yes
Changes in sleep	No	Yes
EYES		
Eye disease	No	Yes
Dry eyes	No	Yes
ENT		
Sinus problems	No	Yes
Persistent hoarseness	No	Yes
Post-nasal drip	No	Yes
Runny nose	No	Yes
Seasonal allergies	No	Yes
CARDIOVASCULAR		
Heart trouble	No	Yes
Chest pain	No	Yes
Rapid / Irregular heartbeat	No	Yes
Heart murmur	No	Yes
Swelling feet or ankles	No	Yes
History of blood clots	No	Yes
History of rheumatic fever	No	Yes
RESPIRATORY		
Frequent cough	No	Yes
Sputum production	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
History of tuberculosis	No	Yes
GASTROINTESTINAL		
Loss of appetite	No	Yes
Stomach ulcers	No	Yes
Gastric reflux / heartburn	No	Yes
Liver problems / hepatitis	No	Yes

GENITOURINARY		
Burning or painful urination	No	Yes
Kidney problems	No	Yes
Blood in urine	No	Yes
Frequent urinary infections	No	Yes
MUSCULOSKELETAL		
Joint stiffness or swelling	No	Yes
Weakness of muscles	No	Yes
Difficulty walking	No	Yes
SKIN		
Rash	No	Yes
Persistent itching	No	Yes
NEUROLOGICAL		
Frequent headaches	No	Yes
Convulsions or seizures	No	Yes
Tremors	No	Yes
Stroke	No	Yes
PSYCHIATRIC		
Memory loss or confusion	No	Yes
Depression	No	Yes
Anxiety	No	Yes
ENDOCRINE		
Thyroid disease	No	Yes
Diabetes	No	Yes
HEMATOLOGIC / LYMPHATIC		
Easily bruising or bleeding	No	Yes
Anemia	No	Yes
ALLERGIC / IMMUNOLOGIC		
Medication allergies	No	Yes
Food allergies	No	Yes

Date _____

Patient Signature: _____ Physician Signature: _____

PATIENT HISTORY QUESTIONNAIRE

PLEASE PRINT

PATIENT NAME: _____ DATE OF BIRTH: _____

Do you smoke? ☐ Yes ☐ No Former Smoker? ☐ Yes ☐ No When did you quit? _____ How long did you smoke? _____ How much did you smoke? _____	If Yes: How much do you smoke? _____ Number of years? _____
Do you drink alcoholic beverages? ☐ Yes ☐ No	How often? _____
Please indicate your marital status: ☐ Married, How long? _____ ☐ Single ☐ Divorced / Separated ☐ Widowed, how Long? _____	
Do you have any Children? ☐ Yes ☐ No	If yes, how many? _____

FAMILY HISTORY: Please comment of health of relatives. (Are they living? Do they have any medical problems? If deceased, please write cause and age at time of death.)

Mother:

Father:

Brothers:

Sisters:

OCCUPATION: Please indicate below the type of work you have done, approximate number of years involved in each occupation.

HOBBIES: Please list below any particular hobbies you pursue.

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PATIENT NAME: _____ DATE OF BIRTH: _____

REASON FOR VISIT / CURRENT COMPLAINT
DR'S NOTES (DO NOT WRITE IN THIS SPACE)

Please list any hospitalizations, including date / reason for hospitalizations (Surgeries / Illness)

Type of Surgery	Year	Medical Hospitalizations	Year

Please List all current medications:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Please list any medications you are allergic to and what happens when you take them.
